STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001094	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA SURGERY CENTER-NOBLESVILLE	9700 E 146TH ST NOBLESVILLE, IN46060

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S0000	The visit was for a licensure survey. Facility Number: 002578 Survey Date: 07-18-11 to 07-20-11 Surveyors: Brian Montgomery, RN Public Health Nurse Surveyor Linda Plummer, RN Public Health Nurse Surveyor QA: claughlin 08/02/11	S0000	Survey dates July 18, 2011 through July 20, 2011Brian Montgomery, RNLinda Plummer, RN	
S0153	410 IAC 15-2.4-1(c) (5) (C) Require that the chief executive officer develop and implement policies and programs for the following: (C) Orientation of all new employees, including contract and agency personnel, to applicable center and personnel policies. Based on document review and interview, the facility failed to follow its policy/procedure for orienting contracted	S0153	An orientation checklist for the facility was completed on 8/12/2011 and approved at the infection control/safety meeting	08/12/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	housekeeping personnel to facility cleaning standards for two employees. Findings: 1. The policy/procedure Housekeeping (last approved 5-2010) indicated the following: The Executive Director, or designee, will orient each housekeeping employee to the Center and the requirements for each area/room. The Center specific orientation checklist contained within this policy will be completed and signed by the employee and Executive Director/designee and placed in the employee file. The Executive Director/designee will oversee the housekeeping services at the Center by using an Environmental Checklist and observing the employee on a monthly basis for six months and then quarterly. 2. Review of the contract housekeeper personnel files for two employees (#P21, #P22) providing housekeeping services for the Center failed to indicate a facility orientation checklist signed by the employees and the Executive Director or designee and failed to contain documentation of monthly observations using an Environmental Checklist by the Executive Director or designee. 3. In interview on 07-19-11 at 1235		on 8/15/2011.This checklist will be used for our contracted housekeeping employees.The two current housekeeping employees reviewed the orientation checklist with the Director on 8/22/2011. This is included as an attachment.The center policy "Housekeeping" was amended on 8/15/2011 "The executive director/degisnee will oversee the housekeeping services at the center by using an Environmental Checklist and observing the employee upon hire and then every 6 months unless issues warrent more frequent observation" A cleaning audit was completed on July 25, 2011 at 6:30pm. This is included as an attachment.All housekeeping employee files were updated and complete as of 8/10/2011.Addendum: The center Maintenance/Supply Team Leader will be responsible for reviewing the detailed maintenance schedule with the supervisor, of the contracted service,assigned to the center. The supervisor of the Cleaning Comapny will be responsible for the training of their employees. The maintenance/supply team leader will observe the contracted cleaning employees for evidence of understanding and competency, this will be done upon hire and every three months, or more frequently if needed. An environmental checklist will be used for this	

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	hours, employee #A2 confirmed the two housekeeping personnel files lacked documentation of orientation and monthly observations using an Environmental Checklist.		assessment. Results will be presented to the Quality Assurance/Infection Control committee meeting on a quarterly basis. Issues that remain chronic, after a three month period, will be taken to the Executive Director and to the Director of Property management.	
S0156	410 IAC 15-2.4-1 (c)(5) (E) Require that the chief executive officer develop and implement policies and programs for the following: (E) Maintenance of current job descriptions with reporting responsibilities for all personnel and annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process.			
	Based on document review and interview, the facility failed to establish a housekeeping job description including performance standards for monitoring accepted levels of cleanliness for two contracted housekeeping personnel. Findings: 1. Review of the facility Job Descriptions manual failed to indicate a current description for housekeeping personnel.	S0156	A housekeeping job description with reporting responsibilites created by QBM, was presented and approved at the infection control/safety committee meeting on 8/15/2011. This job description is kept in each individual contracted employee's file, not in the general job description binder. This is included as an attachment. Performance standards have been met as evidenced by the cleaning audit attached for S 0153.	08/15/2011

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	2. On 07-18-11 at 1030 hours, employee #A2 was requested to provide a housekeeping job description and none was provided prior to exit. 3. On 07-19-11 at 1235 hours, employee #A2 confirmed the facility lacked a job description for contracted housekeeping personnel.			
S0162	410 IAC 15-2.4-1 (c)(5) (G) Require that the chief executive officer develop and implement policies and programs for the following: (G) Ensuring cardiopulmonary resuscitation (CPR) competence in accordance with current standards of practice and center policy for all health care workers including contract and agency personnel, who provide direct patient care. Based on policy and procedure review, job description review, employee personnel file review and interview, the facility failed to ensure CPR (cardiopulmonary resuscitation) competency for 2 of 10 staff files reviewed (P7 and P9). Findings: 1. at 8:30 AM on 7/20/11, review of the policy and procedure "Certifications	S0162	The two staff people cited on this tag completed their CPR training on 8/11/2011. Verification is included as an attachment. The policy "Certifications required, CPR/ACLS/PALS/PPD administration certification" was amended to include . . .all new employees must have CPR certification within 1 month of hire. For those employees with direct patient care, CPR certification must be completed prior to completion of department	08/11/2011

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	Required CPR/ACLS (advanced cardiac life support)/PALS (pediatric advanced life support)/PPD (purified protein derivative) Administration Certification", indicated under "Purpose": "...A. All direct employees of the Center, regardless of position, will maintain current CPR certification as a condition of employment..." 2. at 10:15 AM and 4:30 PM on 7/19/11, review of personnel files P7 and P9 indicated: a. staff member P7: A. was a RN (registered nurse) who began work on 7/5/11 B. had a job description stating under "Education/Experience Requirements"..."...CPR Certification..." C. was lacking any documentation of CPR certification/competency b. staff member P9: A. was a "Supply/Equipment Team Leader" with a hire date of 9/1/04 B. had a job description with "Education Requirements" which included "...CPR Certification..." C. had no documentation of CPR certification/competency in the employee file 3. interview with staff member NA at 4:10 PM on 7/19/11 indicated: a. the CPR trainer is off this week and		orientation, not to exceed 1 month from the date of hire. This policy will be presented to the Operations Committe and the Board of Managers, for approval, on November 7, 2011.Addendum: The administrative and credentialing coordinator of the center will be responsible for the verification of required certifications. A checklist of all mandatory in services and required certifications will be kept on all employees. The administrative and credentialing coordinator will report any incomplete requirements to the Executive Director.	

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	can't train staff member P7 until next week b. the job description for P7 indicates CPR competency will be present at the time of hire, there is no stipulation for obtaining competency within a certain time frame after hire 4. interview with staff members NA and NB at 11:00 AM on 7/20/11 indicated: a. it is unknown when the CPR competency for staff member P9 expired, as there is no documentation present in the employee file b. the job description for staff member P7 implies that CPR competency will be present at the time of hire, not after employment begins c. it is expected that staff member P9 will take CPR classes next week when the trainer returns			
S0176	410 IAC 15-2.4-1 (c)(5) (M) Require that the chief executive officer develop and implement policies and programs for the following: (M) Demonstrating and documenting personnel competency in fulfilling assigned responsibilities and verifying in-service in special procedures. Based on document review and interview, the facility failed to document contracted housekeeping personnel competency for	S0176	Evidence of training was provided by QBM (Quality Building maintenance) for the employees	08/10/2011

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	cleaning and disinfecting operating rooms and sterile processing areas at the surgery center for two contracted employees. Findings: 1. The policy/procedure Housekeeping (last approved 05-2010) indicated the following; The Indiana Surgery Center Noblesville will provide and maintain a functional and sanitary environment for surgical services to avoid sources and transmission of infections and communicable diseases.... all services performed shall be monitored to assure their performance is consistant with accepted (infection control) standards. 2. During an interview on 07-19-11 at 1235 hours, employee #A2 confirmed the two housekeeping personnel files lacked documentation of cleaning competency for operating room and sterile processing areas.		working in our facility. This included bloodborne pathogens procedures, HIPAA compliance, Preventing workplace injuries, Fire and Safety training, Risk Management and compliances and Infection Control. An audit was also completed by the Executive Director on July 25, 2011 and reviewed with the employees supervisor. This has already been included as an attachment.Addendum: The maintenance and supply team leader will evaluate the contracted employees of the cleaning company, for understanding and competency. The audit/checklist, with the cleaning requirements, will be reviewed upon hire of the contracted employee and every three months. These results will be presented at the quarterly quality assurance/infection prevention committee meeting. The contracted company's supervisor will be advised by the team leader of any questionable processes, and re-training of the employee will be required. The team leader will re-evaluate the employee one month post re-training, for understanding and competency. Should the competency remain questionable, the maintenance/supply team leader will report to the Executive Director of the center and the Director of Property management.	

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S0310	410 IAC 15-2.4-2(a)(1) The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the facility failed to monitor 4 contracted services through the Quality Assessment and Improvement (QA&I) program. Findings: 1. The policy/procedure Quality Risk Management, Assurance, and Improvement (reviewed 8-09) indicated the following: The QA review process will include ... review of Contracted Services quarterly. 2. The QA&I report entitled Outsourced Services - Agreement 2011 lacked evidence of monitoring and/or standards for 4 services (housekeeping, sterilizer/cleaner/washer service, medical gas, and fire/safety service). 3. During an interview on 07-19-11 at 1200 hours, employee #A2 confirmed the facility was not monitoring the 4 services indicated above.	S0310	The contracted services of Housekeeping; Medical gas; Sterilizer/cleaner/washer services and Fire and Safety services were cited as not included in our QA program. These services were all included in our quarterly QA (as evidenced by attachment) however the surveyors requested specific standards and norms, while the previous evaluations have been subjective, based on general feedback and observation, by the executive director. New contracted services QA forms have been developed which include specifics to monitor and the standards by which they are held. These were developed on 8/19/2011. They will be submitted to the Operations committee and the Board at the November 7, 2011 meeting for approval. Addendum: The Executive Director will be responsible for conducting quarterly quality assurance on contracted services.	08/19/2011

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S0434	410 IAC 15-2.5-1(f)(2)(E)(iv) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iv) Aseptic technique, invasive procedures, and equipment usage. Based on observation, policy and procedure review, and interview, the infection control practitioner failed to ensure that aseptic technique was utilized in relation to the wearing of masks around the neck, or carried throughout the facility, for 4 staff observed. Findings: 1. at 12:05 PM on 7/19/11, in the pre op area: a. a physician had their surgical mask dangling around their neck b. staff member NB was carrying a surgical mask with them from the board room to the pre op area 2. at 12:10 PM on 7/19/11, while observing in OR (operating room) #1, in the company of staff member NB, it was observed that staff member NB was utilizing the surgical mask they had been	S0434	The infection prevention practitioner failed to ensure that aseptic technique was utilized in relation to the wearing of surgical masks around the neck, and also carried through facility. The AORN standard was referred to, in the facility policy, which says "A fresh, clean surgical mask should be worn for every procedure" This was discussed at the infection prevention/safety committee meeting on 8/15/2011 and will also be discussed at the OR staff meeting scheduled for 8/25/2011. This was also reviewed at the all medical staff meeting; operations committee and board meeting on 8/8/2011. The infection prevention personnel will audit compliance of this policy over the next month. The amended policy is attached.Addendum: The nursing team leaders will be responsible for auditing this policy on a quarterly basis. Any variance by nursing personnel will	08/08/2011

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	carrying around the facility 3. at 1:15 PM on 7/19/11, in the post op (patient room) area, two more staff members (which included one physician/surgeon) were observed wearing masks dangling around their necks and staff member NB continued to carry the same surgical mask with them 4. at 3:15 PM on 7/19/11, review of the policy and procedure "Dress Code Guidelines, Instrument Room, O.R., P.A.C.U. (post anesthesia care unit), Patient Rooms, Support Services", with a last reviewed/revised date of 5/2011, indicated: a. under "Purpose", it reads: "...This policy complies with the 2011 AORN (Association of periOperative Registered Nurses) standards and Recommended Practices which states 'surgical attire is worn to provide a barrier to contamination that may pass from personnel to patients as well as from patient to personnel." b. under "Purpose", it reads: "...E. Wear a single surgical mask where open sterile supplies or scrubbed persons are located...On becoming moist the mask should be changed..." 5. at 3:15 PM on 7/19/11, review of the policy and procedure "Scrub Routine", with a reviewed/revised date of		be addressed by the nursing team leaders. Any variance by Medical Staff will be reported to the Excutive Director for follow up and education. Any chronic infractions of this policy, by the medical staff, will be presented to the Quality Assurance/Infection Prevention committee by the Executive Director. Chronic infractions of this policy by nursing personnel will be handled at the department level.	

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	8/11/2009, indicated: a. under "Purpose", it reads: "...A...a...iii. Place clean mask over nose and mouth and tie securely to prevent venting..." 6. at 4:30 PM on 7/19/11, interview with staff member NB indicated: a. "masks should be changed with each surgical case" as per recommendations by AORN and standards of practice 7. interview with staff member NC at 2:30 PM on 7/20/11 indicated: a. even though the policies in 4. and 5. above are not specific to the wearing of a new mask with each surgical case, it is expected that staff will don a new mask prior to entering the surgical suite for each procedure b. personnel surveillance by the infection control practitioner might clarify if staff are changing masks prior to new cases, as is expected			

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S0442	410 IAC 15-2.5-1(f)(2)(E)(viii) The infection control committee responsibilities must include, but are not limited to: (E) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (viii) An employee health program to determine the communicable disease history of new personnel as well as an ongoing program for current personnel as required by state and federal agencies. Based on personnel file review, policy and procedure review, and staff interview, the infection control committee failed to ensure the infection control plan was effective in relation to the documentation of time given and time read for TB tests; self reported Varicella immunity, and negative titers lacking follow up, for 10 of 10 employee files reviewed (P1 through P10). Findings: 1. at 11:30 AM on 7/19/11, review of the policy and procedure "Employee Occupational Health", with a last reviewed/revised date of 8/11/2009, indicated: a. under "Purpose", it reads: "...H. Immunization Vaccines: a. Immunization	S0442	1. The forms that were surveyed in the employee files did not indicate the time, the TB tests, were given and the time they were read. The TB results documentation was updated on 8/9/2011 to include the time the test was given and the time it was read. These forms also include the certification expiration date of the person reading the results. The network employee occupational health department accepted TB reports, as well as immunization reports from outside sources, with out verification of the cerification of the person that read the results. 2.There was also concern over "equivical" status for rubella results and self reporting of varicella immunity. A conference call was held with Lisa Weatherford, the Network Health	09/06/2011

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	vaccines for flu, and other such programs, when offered during designated periods and approved by EOHS (employee occupational health services), are available, upon the request of the employee or Network volunteer, in EOHS." b. under "Purpose", it reads: "...L. Annual Testing Program: a. All employees will be required to have a PPD (purified protein derivative) test within the last twelve (12) months. Employees will also be required to provide documented proof of Rubella and Rubeola immunity along with review of Respirator Clearance, where applicable." 2. at 10:15 AM, 1:30 PM, and 4:10 PM on 7/19/11, review of personnel files indicated: a. staff members P1, P2, P3, P4, P5, P7, P8, P9 and P10 had: A. a "Tuberculin Skin Test (TST)" form which states: "*must be read 48 to 72 hours after test has been administered" B. had dates the TB tests were given, and dates the TB tests were read, but were lacking a time given and a time read to indicate the TB tests were read between 48 and 72 hours as required b. staff members P3, P5, P6, P8, P9 and P10 had self reported Varicella immunity		Administrator, on 8/19/2011. A review of their policies indicated a TB screen will be completed by EOHS on all new hires, any previous testing where the certification cannot be verified will be repeated.Rubella immunity is also mandatory for all employees If the immunization cannot be documented by titer results then the the vaccine will be administered. The only exception would be if the employee had medical verification, from their physician, that the vaccine should not be given. These employees will be counseled on their need to be off work, should an outbreak occur. 3. All employees of the ISC Noblesville will be re tested for varicella titers if they do not have them currently documented in their file. This will be arranged with Barb Cooper,from the EOHS and provided to employees at no cost. This is scheduled to occur the first week in September 2011. Anyone that declines the vaccine will be notified of the network policy regarding "off time" in case of an outbreak. Self reporting of varicella exposure will no longer be accepted. All medical files on site will contain the results of the immunizations of the employees. Addendum: Tracking and completion of employee files will be the responsibility of the administrative and credentialing coordinator.	

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	c. staff member P8: A. had a documented "equivocal" status for Rubella (test results = 6.0 with a 5.0 to 9.9 being "Indeterminate; repeat testing on a new sample in 10 - 14 days is recommended" written on the lab form) B. had a note written 4/2/04, on the lab form, that reads: "Informed of results" and another note that reads: "Notified Supervisor...to have [employee] call EOHS" C. lacked any further information related to follow up in relation to the lack of known immunity to Rubella d. staff member P9: A. had a copy of a lab form with "<8" and a note of "...Questionable Immunity..." with a hand written note of "Notice sent 11/3/92 B. had another copy of a lab form with the reading: "Rubella Screen NEG" and a hand written note: "Noted:...MD should be notified" C. lacked any further information related to follow up in relation to the lack of known immunity to Rubella (and whatever test was <8 on the first lab form) 3. interview with staff member NA at 9:15 AM on 7/20/11 indicated: A. the current health policy, as stated in 1. above, lacks language related to Varicella expectations			

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	B. it cannot be certain that employees who self reported Varicella disease history or immunity are immune in the event of a community out break of Varicella/Chicken Pox C. the occupational health offices accepted copies of lab results for P8 and P9 from previous employers without following up to see that the tests were repeated for clarification/confirmation of results, or to see if boosters might have been given D. the facility infection control plan does not address what to do if there are results of non immunity when titers are done, or the exempting of employees from work if they are found to be non immune when a particular communicable disease has presented itself in the community			
S0620	410 IAC 15-2.5-3(c)(5) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (5) Plain paper facsimile orders, reports, and documents are acceptable for inclusion in the medical record if allowed by the center policies. Based on document review and interview, the facility failed to have a current	S0620	Our current policy on maintaining the documentation of the medical record did not include that we	11/07/2011

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	policy/procedure allowing plain paper facsimile documents into the patient medical record. Findings: 1. The policy/procedure Facsimile Orders, Reports, and Documents (last approved 07-2000) failed to indicate that plain paper facsimile documents were acceptable to include in the medical record. The policy/procedure included a hand-written statement that indicated the following; 6. No faxed documents will be accepted by the facility, unless on plain paper. 2. During an interview on 07-19-11 at 1420 hours, employee #A2 confirmed the policy was undergoing revision and the hand-written statement was a draft copy.		accept plain paper facsimile documents into the patient medical record. This policy has been revised (see attached) and will be presented to the Operations committee and Board of Managers at the next meeting November 7,2011. This will be reviewed with the business office employees at their next staff meeting on 8/26/2011.Addendum: The Business Office Team Leader is responsible for the medical record and the enforcement of the policy accepting plain paper facsimile documents. This may be delegated to members of her team.	

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S0624	410 IAC 15-2.5-3(c)(7) An adequate medical record must be maintained with documentation of service rendered for each patient of the center as follows: (7) The center shall ensure the confidentiality of patient records. The center must develop, implement, and maintain the following: (A) A procedure for releasing information or copies of records only to authorized individuals, in accordance with federal and state laws. (B) A procedure that ensures that unauthorized individuals cannot gain access to patient records. Based on document review, observation and interview, the facility failed to ensure that medical records were not accessible to unauthorized individuals. Findings: 1. The policy/procedure Medical Records, Explanation of Chart (last approved 08-2009) indicated the following; All medical records, including those stored offsite, will be protected from loss, tampering, alteration, destruction, and unauthorized or inadvertent disclosure. 2. During a tour on 07-19-11 at 0935	S0624	Our Surveyors felt the rolling carts, with patient demographic and insurance information, were not secure enough in the front business office, under the counter. All housekeeping personnel sign a HIPPA form upon hire. Any accidental exposure to patient information by the housekeeping personnel is covered by this release. These are attached for review. The rolling carts are now moved to the Business Office Team Leaders office after hours, which is locked. This will be discussed at the business office staff meeting Friday 8/26/2011.Addendum: New carts were purchased with locks, to secure the cabinets containing patient information at	08/26/2011

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	hours, in the reception area of the waiting room, two open carts containing medical records for current patients were observed. 3. On 07-19-11 at 0935 hours, #A6 indicated that the carts containing medical records were stored under the counter when not needed and unsecured overnight when the housekeeping employees were cleaning the surgery center. 4. On 07-19-11 at 1630 hours, employee #A2 confirmed the medical records located in the reception area were not secured from unauthorized access by contract houseekeeping personnel and the housekeeping staff were not authorized to access protected health information by the facility.		the receptionists desk. The receptionist on duty, at closing, will be responsible for securing the rolling carts that contain patient information. The Business Office team leader will be responsible for training the receptionist on this process.The policy entitled "Face Sheet, Registration Documentation" has been modified to include this process.	

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S0772	410 IAC 15-2.5-4(b)(3)(M) These bylaws and rules must be as follows: (3) Include, at a minimum, the following: (M) A requirement that a medical history and physical examination be performed as follows: (i) In accordance with medical staff requirements on history and physical consistent with the scope and complexity of the procedure to be performed. (ii) On each patient admitted by a physician, dentist, or podiatrist who has been granted such privileges by the medical staff or by another member of the medical staff. (iii) Within the time frame specified by the medical staff prior to date of admission and documented in the record with a durable, legible copy of the report and with an update and changes noted in the record on admission in accordance with center policy. Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to implement it's policy related to updates to History and Physicals for 1 of 3 transfer patients (N3). Findings: 1. at 11:00 AM on 7/20/11, review of the	S0772	The facility policy for Medical Records states the H&P will be reviewed and updated, as needed, on the date of service. The facility provides the physician offices with H&P forms that have a designated area for date of service review and signature. I have included the blank H&P that the facility provides to the physicians offices as an attachment. The facility also has	08/08/2011

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	policy and procedure "Medical Records, Explanation of Chart", with a reviewed/revised date of 8/11/2009, indicated: a. "A. Maintenance of Health Records a....ii. History and Physical (H&P) Current history and physical dictated or written by attending physician...the physician must review/update on date of service..." 2. review of transfer records at 2:00 PM on 7/18/11 and 9:00 AM on 7/19/11 indicated: a. pt. N3 had a H & P on 3/8/10, but was lacking an update on the day of surgery, 3/9/10 3. interview with staff member NA at 11:00 AM on 7/20/11 confirmed the history and physical for pt. N3 was not updated as required by policy and procedure		a stamp for any other H&P that may come through without the designated area for DOS review. The stamp states" reviewed by" and has a signature line, date and time. The nurses are responsible for reviewing each H&P before the DOS to identify which may need stamped. This was again reviewed at the Medical Staff meeting and Operations committee meeting on 8/8/2011.This information will again be reviewed at each department's office meeting. Business office 8/26/2011: OR 8/26/2011 and Patient rooms 8/25/2011. Addendum: The network medical records consultant will analyze 20 random medical records each quarter. The appropriate time and signature on the H&P will be one of the documents reviewed each quarter. The results will be reported to the Business Office Team Leader and the Executive Director. A quarterly plan of correction/explanation will be reported back to the medical records consultant. Any Physician with chronic incomplete medical records will be presented at the quarterly Quality Assurance Committee meeting.	

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S0830	410 IAC 15-2.5-4(c)(1)(F)(i) The medical staff shall write and implement policies and procedures and the governing body shall approve policies and procedures which include but are not limited to, the following: (F) The delineation of preanesthesia, intra-operative, and post-anesthesia responsibilities as follows: (i) The completion, within forty-eight (48) hours before surgery, of a preanesthesia evaluation for each patient by an individual qualified to administer anesthesia for all types of anesthetics other than local and updated according to center policy (when more than forty-eight (48) hours) before surgery.			
	Based on policy and procedure review, patient medical record review, and staff interview, the facility failed to indicate that a pre anesthesia evaluation was performed by the practitioner on the day of surgery for 2 of 15 patients (N1 and N2), and failed to provide a complete evaluation for 3 of 15 patients (N2, N3, and N4). Findings: 1. at 1:45 PM on 7/20/11, review of the policy and procedure "Medical Records, Purpose and Responsibility", with a most recent revised/reviewed date of 8/11/2009, indicated: a. under "C. Requirements", it reads:	S0830	All patients, in our center, get a complete pre-anesthesia evaluation prior to surgery. Our electronic medical record records the electronic signature when the pre anesthesia form is printed. The 2 charts that were cited were on patients that had a complete pre anesthesia evaluation, but the anesthesiologist did not get the paperwork printed on the DOS. The date reflected on the form was the date of printing. We had a discussion with our EMR vendor the morning of 8/22/2011 requesting a change to be made that would require the signature on the pre anesthesia section before the anesthesia record could be closed. They will look into this as a possibility. The staff	08/08/2011

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	"...c. Pre-Operative Anesthesia Note i. Gen/Mac/Regional Anesthesia ii. Notes: Must include a notation of anesthesia risk, anesthesia, drug and allergy history, any potential anesthesia problems identified, and the patient's condition prior to induction of anesthesia by an anesthesiologist." 2. review of patient medical records through out the survey process of 7/18/11 to 7/20/11 indicated: a. pt. N1 had: A. a "Pre-Anesthesia Evaluation" form for the surgery day of 2/16/11 that was "digitally signed by:" the physician "on 3/2/11..." b. pt. N2 was a 50 year old pt. who had: A. a "Pre-Anesthesia Evaluation" form for the surgery day of 4/20/10 that was "digitally signed by:" the physician "on 4/29/10..." B. no Blood Pressure noted in the Vitals section of the "Pre-Anesthesia Evaluation" form C. no documentation of the anesthesia type or the ASA (American Society of Anesthesiologists) classification on the "Pre-Anesthesia Evaluation" form c. pts. N3 and N4 had no documentation of the anesthesia type or the ASA classification on the "Pre-Anesthesia		in PACU and in patient rooms will be re-educated on this requirement at the staff meeting on 8/25/2011. Phase II nurses will review the chart for completeness prior to anesthesia leaving the building.There were 3 files cited by the surveyors, that did not appear to have a complete evaluation. The information that was missing was documented in the Anesthesia notes and the intraop nursing documentation of the medical record. There was also an area on the pre anesthesia evaluation record for this same information. Our 3 Anesthesiologists were reminded , on 8/8/2011, each section needs to be fully completed.Addendum: The post operative nursing personnel will monitor daily the inclusion of the printed pre anesthesia form in the medical record. A checklist will be kept by the printer in the PACU to check off daily printed pre anesthesia records. Should a report be missing, the post operative nurse will contact the anesthesiologist for completion on the day of service. If the anesthesiologist has left for the day, the information will be reported to the Executive Director, who will either print the pre anesthesia form or contact the anesthesiologist to complete. The EMR vendor has made changes to the software that require a printed pre anesthesia form before the anesthesia record	

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	Evaluation" form 3. Interview with staff member NC at 1:30 PM on 7/18/11 indicated: a. the anesthesiology practitioner must hit "done" on the computer in the pre anesthesia "form" area of the computer for it to "digitally" sign the practitioner's name b. since the date of the digital signature is later than the surgery date for pts. N1 and N2, it cannot be determined that the anesthesiology practitioner actually evaluated those patients on the day of surgery c. the pre anesthesia forms for pts. N2, N3, and N4 are incomplete, per facility policy, for Blood pressure, anesthesia type, and ASA classification 4. at 1:45 PM on 7/20/11, staff member NA provided a copy of an education document dated 9/16/10 in which the business office manager had instructed medical records staff to be diligent in reviewing the pre anesthesia form for completion of the Anesthesia type and the ASA classification by the anesthesia personnel		can be closed.	

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S1010	410 IAC 15-2.5-6(3)(A) Pharmaceutical services must have the following: (3) Written policies and procedures developed, implemented, maintained, and made available to personnel, including, but not limited to, the following: (A) Drug handling, storing, labeling, and dispensing. Based on policy and procedure review, formulary review, patient medical record review, and staff interview, the facility failed to ensure that medications were given as ordered, by a credentialed physician for 5 of 15 patients (N1, N3, N4, N8, and N14), and failed to have medications on standing orders removed once removed from the formulary, for pt. N13. Findings: 1. at 1:35 PM on 7/20/11, review of the policy and procedure "Medications, Ordering/Receiving/Handling & Administering", with a last dated reviewed/revised of 8/11/2009, indicated: a. under section "G. Medication Administration", it reads: "Only R.N.s (registered nurses) may administer medications with a verbal or written order from a physician. The type of drug, dosage, route of administration and rate of	S1010	1. Darvocet N 100 had been removed from the facility formulary, but had not been taken off of standing orders. On 8/22/2011 Darvocet N 100 was removed from the standing post op orders of Dr. S.Sexson; Dr. T. Cittadine; Dr. P. Kay and the post op anesthesia orders for adults.2. The facility had a medical record that had a physician order by a physician not credentialed on our staff. The Physician credentialed at the center that wrote the order was Dr. Sue Lanter. Our EMR has a drop down list of surgeons in the network to select from. If the nurse does not move the cursor away from the field before scrolling down the page the windows application will scroll through the field it is still on. The physician selected was Dr. Earl Lanter, who is not credentialed at our center. The nurses in the patient rooms and the operating rooms will be reminded of this issue at their next staff meetings:	08/22/2011

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	administration...must be specified by the anesthesiologist or attending physician..." 2. review of the 5/2008 to 5/9/2011 formulary indicated: a. Darvocet N 100 u/d was listed on the formulary at that time b. Lortab elixir was listed on the formulary, but not Lortab in a tablet form 3. review of the "approved 5/9/2011" formulary indicated: a. Darvocet N100 was no longer on the formulary b. Lortab elixir was listed on the formulary, but not Lortab in a tablet form 4. review of patient medical records through out the survey process of 7/18/11 to 7/20/11 indicated: a. pt. N1: A. had documentation on the "Phase 2 Recovery" form of being given Vicodin 1 tab at 15:30 B. had documentation on the "Phase 2 Recovery" form (in the "Case Medications" section) of being given Lortab 5 500 mg 1 tab at 15:30, with no order for Lortab in the medical record C. had documentation on the "Phase 2 Recovery" form (in the "Case Medications" section) that the ordering physician for the Lortab was not a physician credentialed at this facility		8/25/2011 and 8/26/2011, A list of all the credentialed physicians at our facility will be given to staff that perform chart analysis. Any unfamiliar name in the medical record will be cross checked with this list.3. The formulary was missing a couple of brand name medications that had been substituted from the vendor-these were drugs of the same formulation that can be used inter changeably on order sets and in documentation. The formulary will be reviewed for accuracy and taken to the Operation's committee and Board of Manager for approval, at the next meeting, November 7,2011.4. Nursing documentation revealed a different brand name in "case medications" than was ordered. The 2 medications were vicodin and lortab; these 2 drugs have the same formulation and can be used interchangeably based on availability. Nursing staff will be counseled on accuracy in charting throughout the medical record. During the formulary evaluation the brand name and generic name for these medications will both be included. All other duplications will also be reviewed as drug shortages can lead to different brand names being delivered by the distributor. Addendum: A policy that will address the process to keep the medication formulary and the standing orders, pre and	

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	b. pt. N3 had documentation on the "Postoperative" page that "2 Tab total for Lortab 5 500 mg" were given at 11:35, but lacked an order for Lortab in the medical record c. pt. N4 had: A. a nursing note in the "Postoperative" pages, on 6/1/2010 at 12:15, that read: "After being treated with po Darvocet at 1115 for Bladder area pain, pt. has denied bladder pain and nausea..." B. no order for Darvocet to be given post operatively d. pt. N8 had documentation on the "Phase 2 Recovery" form (in the "Case Medications" section) that the ordering physician for the Lortab elixir that was given was ordered by a physician not credentialed at this facility e. pt. N13 had surgery on 5/13/11 and had standing orders (post op orders) that still listed Darvocet N 100 to be given prn for pain, even though this medication was discontinued from the formulary 5/9/11 f. pt. N14: A. had documentation on the "Postoperative" form of being given Vicodin 1 tab at 10:30 B. had documentation on the		post op, current will be presented to the operations committee and board of managers at the next meeting November 7, 2011. This policy will provide for an annual review of the formulary and standing orders. This will be the responsibility of the Patient Rooms/PACU team leader. Discrepancies and/or requested changes will be taken to the Executive and Medical Director for discussion. Recommended adjustments will be taken to the operations committeefor approval.The policy will also include a process for medication substitution. If a medication has been ordered, and the center does not have that particular brand name, but they have a medication with the same formulation, either in generic form or by another brand name, the available medication can be substituted. Any questions with regards to this process can be directed to the ordering physician or to the medical director.In reference to #2 above: A quarterly audit of medical record accuracy will be performed by the network medical records consultant. A report of her findings will be presented to the Business Office team leader and to the Executive Director. The Executive Director will be responsible for any plan of correction around these findings.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"Postoperative" form (in the "Case Medications" section) of being given Lortab 5 500 mg 1 tab at 10:30, but lackded a physician order for Lortab 5. interview with staff member NC at 1:30 PM and 4:00 PM on 7/18/11 indicated: a. the physician who is listed as having ordered pain medication for pts. N1 and N8 is not credentialed at this facility to order medications--the nurse "pulled" up the wrong physician name on the computer b. nursing staff are using Vicodin and Lortab interchangeably--"they have the same drug properties" 6. interview with staff member NC at 9:00 AM on 7/19/11 indicated: a. Lortab is not on either the 5/2008 to 5/9/11 or the 5/9/2011 formulary b. with drug shortages, it "depends on which medication we can get from the distributor" whether Vicodin is given for pain, or Lortab is substituted c. the generic for Vicodin and Lortab is hydrocodone with acetaminophen, this could be placed on the formulary, then either medication could be given interchangeably or, Lortab could be added to the formulary for those times that Vicodin is back ordered and Lortab is substituted by the distributor			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15C0001094	A. BUILDING 00 B. WING	07/20/2011

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	7. at 4:00 PM on 7/19/11, interview with staff member NA, and review of the current post op order form for the physician who did pt. N13's surgery, indicated Darvocet is still on these standing orders, even though removed from the formulary in May			
S1168	410 IAC 15-2.5-7(b)(4)(B)(iii) (b) The condition of the physical plant and the overall center environment must be developed and maintained in such a manner that the safety and well being of patients are assured as follows: (4) The patient care equipment requirements are as follows: (B) All patient care equipment must be in good working order and regularly serviced and maintained as follows: (iii) Appropriate records must be kept pertaining to equipment maintenance, repairs, and electrical current leakage checks and analyzed at least triennially. Based on document review and interview, the facility failed to provide documentation of triennial analysis of preventive maintenance records on all	S1168	The Indiana Surgery Center Noblesville, in conjunction with the clinical engineering department of Community Health Network, will review and evaluate	08/22/2011

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	patient care equipment in use at the facility. Findings: 1. Review of preventive maintenance records lacked evidence of triennial analysis by the facility or the contracted service provider for patient care equipment. 2. During an interview on 07-19-11 at 1200 hours with employee #A4, the employee confirmed that a triennial analysis of all patient care equipment was not being performed.		the preformance assurance testing of all life support, and non life support, medical equipment on a yearly basis. Review will include all routine preventive maintenance on medical equipment; the service record for repairs of all medical equipment and evaluation of any trends. On an annual basis, we will ensure that all medical equipment has been inspected, tested and maintained. I have attached the reviewAddendum: The maintenance/supply team leader will be responsible, along with the clinical engineering department, for keeping current records of all preventive maintenance and repairs of the medical equipment in the center. The Team Leader will also verify an annual evaluation of this data will be done to help identify any ongoing medical equipment issues. Any identified medical equipment with a long history of repairs will be reported to the Executive Director, for possible addition to the capital budget.w summary for 2010 and the medical equipment management plan.	